STOCKTON UNIFIED SCHOOL DISTRICT
OFFICE OF RISK MANAGEMENT

ATHLETIC ACCIDENT CERTIFICATION

SCHOOL_____

STUDENT'S NAME_____

I.D. NUMBER_____ DATE OF BIRTH_____

ADDRESS_____

HOME PHONE NO._____ CELL PHONE NO._____

SPORT_____

BRIEFLY DESCRIBE HOW THE INJURY OCCURRED_____

_____

_____

_____

DATE OF THE INJURY_____ TYPE OF INJURY_____

_____

_____ _____

I certify that the above student was injured while participating in the above extramural interscholastic sport and I did ☐ /did not ☐ witness the accident.

COACH'S NAME_____

DATE MAILED TO RISK MANAGEMENT_____

COMMENTS_____

_____

_____ Date 9/7/23

Coach's Signature

PLEASE FILE THIS CERTIFICATION WITHIN THREE (3) DAYS AT:

OFFICE OF RISK MANAGEMENT
55 SOUTH MADISON STREET, STOCKTON, CA 95203
(209) 933-7110 - 8:00 A.M. – 4:30 P.M.